

Health Statement by Licensed Medical Personnel

Participant's Name _____ Birth Date _____

Trip Dates _____

The program proposed for the above named participant requires participation in activities which are physically challenging, at "high altitude" (9,000 to 13,000+ feet) and in a remote, wilderness environment. These factors can cause surges in blood pressure and heart rates as well as other conditions. Therefore, all participants must be free of medical or physical conditions which might create undue risks to themselves or others. Your response to these questions will aid in the medical screening and care of the participant.

I have examined the above participant within 12 months of program date. Date of examination _____

In my opinion, the above participant ___ is ___ is not able to participate in the described program.

Description of any limitation or restriction on program activities _____

The participant is under the care of a physician for the following conditions _____

Current treatment at the time of this report includes _____

Prescribed medications being used by participant _____

Over-the-counter medications used by participant _____

Any dietary restrictions _____

Known allergies or drug reactions _____

Signature of Physician or Nurse Practitioner _____

Printed Name _____ Title _____

Address _____

Phone _____ Date _____

**** Attach Colorado Certificate of Immunization**